



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

COLUMBIA LRMC  
C/O DAVIS FULLER JACKSON KEENE  
11044 RESEARCH BLVD STE A-425  
AUSTIN TX 78759

#### **Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-98-C069-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "While the guideline was invalidated due to procedural error and 'fair and reasonable' was not established by the Supreme Court decision, the original suit was brought because the guideline was felt to be a financial hardship on the hospital provider... We understand 100% reimbursement may not be appropriate and will discuss a reasonable settlement."

**Amount in Dispute:** \$4,459.30

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Petitioner is not entitled to further payment from the Fund because the Fund has already paid Petitioner all moneys due under the statutory standard for payment established by §413.011, Tex. Labor Code... the Fund also contends that Petitioner's evidence fails to meet Petitioner's burden of proof to establish by a preponderance of the credible evidence that the Fund's reimbursement methodology falls short of the statutory standards for payment set forth above."

**Response Submitted by:** Texas Workers' Compensation Insurance Fund, PO Box 12029 Austin, Texas 78711-2029

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 1997	Outpatient Hospital Services	\$ 4,459.30	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the

procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the fair and reasonable reimbursement for services not identified in an established fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on May 8, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - M – REIMBURSED ACCORDING TO FAIR AND REASONABLE STANDARDS.
  - G – REIMBURSEMENT FOR THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE.
  - F – ALL DOCTOR PROFESSIONAL CHARGES MUST BE BILLED ON A HCFA-1500 BILLING FORM.

## **Findings**

1. This dispute relates to outpatient medical services. The services in dispute were not identified in an established fee guideline during the disputed dates of service; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission."
2. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
3. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical records to support the services as billed, or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
4. Review of the submitted documentation finds that:
  - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
  - The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
  - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	December 19, 2011 Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**